Aflac Claim Form

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ISFP0B7Y3X33425067320112042012I

Policyholder Information:

LAST NAME	FIRST NAME	BIRTHDATE	POLICY NUMBER	CLAIM NUMBER
Anderson	Cory	05/04/1966	P0B7Y3X3	342506732

ADDRESS
1513 5 And One Half Ave Ne

CITY	STATE	ZIP
Jamestown	ND	58401

Patient Information:

LAST NAME	FIRST NAME	MIDDLE INITIAL
	Kristi	

BIRTHDATE	GENDER	RELATIONSHIP TO POLICYHOLDER
08/06/1970	F	Spouse

What We Need To Process Your Claim:

Before we can begin review of your claim, you will need to sign this claim form and attach documentation for each service related to this claim from the healthcare provider(s) containing the following information:

- Diagnosis.
- Name and address of servicing health care provider.
- Date(s) services provided.
- Name and address where services were received (if different than the servicing health care provider).
- Description of services.

Service related items above can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA1500 non-hospital bill.

Mail or fax all documents to American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department
Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
Toll-free fax number: 1.877.44.AFLAC (1.877.442.3522)

Claim Information - Claim Details and Related Services:

Date of Accident?

11/18/2012

Is this the patient's first claim for this condition?

Yes

What was the first date of service for this claim?

12/04/2012

Was this a motor vehicle accident in which the patient was the driver?

No

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

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Claim Information - Claim Details and Related Services:

Was the accident on the job?

No

Accident Details (include nature of accident and injuries sustained)

I fell into my side mirror on my car as I was accidentally pushed and was on icy ground, it messed up my hips and alignment and needed to seek care.

Was the patient transported to a medical facility by air or ground ambulance?

No

Was the patient confined to a hospital for this condition?

No

Was the patient prescribed anything to help him or her walk or move around, such as crutches, a brace, a wheelchair, or another device?

No

Was surgery performed as a result of this condition?

No

Did the patient receive physical therapy from a licensed physical therapist for an injury sustained in this accident?

No

Did the patient require and receive any follow-up treatment from a physician for this condition?

No

By signing this claim form, I verify the information above is accurate and correct.

Kristi Anderson

Policyholder Signature **Family Relationship, if not Policyholder** **Date**

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Claims Authorization to Obtain Information

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Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas, with the exception of the health care provider section of this form, should be completed.**
2. **This form must be signed and dated by the claimant/patient, guardian or authorized representative below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased person, please check here.** ❒
4. **If you are the authorized representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on his or her behalf.**
5. **Fax this form to 1-877-442-3522 or return the form to Aflac, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999, as soon as possible in order to expedite claim review.**

Policyholder Name:	**Policy Number(s):**	**Date of Birth:**
Cory Anderson		05/04/1966

Policyholder Address:

1513 5 And One Half Ave Ne, Jamestown ND 58401

Claimant/Patient Name (if different from named policyholder listed above):	**Date of Birth:**
Kristi	08/06/1970

This authorization will be valid for a period of two years from the sign date, unless a lesser time frame is indicated. Alternate Expiration Date:

Name and address of health care provider(s), company, or individual authorized to release the requested information (this section will be completed by Aflac)**:**

Purpose of Disclosure:
Evaluate claims for benefits during the time this authorization is valid.

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include but is not limited to any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under federal and state law such as: alcohol abuse, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**